Original Public Report

Report Issue Date: December 12, 2023
Inspection Number: 2023-1629-0005
Inspection Type:
Complaint
Critical Incident

Licensee: Glen Hill Terrace Christian Homes Inc.
Long Term Care Home and City: Glen Hill Terrace, Whitby

Lead Inspector	**Inspector Digital Signature**
Rexel Cacayurin (741749)	

Additional Inspector(s)
Rita Lajoie (741754)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 30-31, 2023, November 1- 3, 6-10, 14-15, 2023

The following intakes were inspected:

- An intake complaint related to residents' care and allegation of neglect.
- An intake complaint related to skin and wound and allegation of neglect.
- An intake related to an allegation of staff to resident neglect.

Note: Compliance orders related to FLTCA, 2021, s. 24 (1) and O. Reg. 246/22, s. 55 (2) (d) were identified in this inspection and have been issued in a concurrent inspection, #2023-1629-0004, dated, December 12, 2023.

The following **Inspection Protocols** were used during this inspection:

Skin and Wound Prevention and Management
Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

1) The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A complaint was received by the director from the resident's Power of Attorney (POA) regarding lack of care and concerns that the resident was not turned every two hours.

Rationale and Summary

A review of resident's skin and wound assessments at the time of admission indicated that they were at high risk for skin breakdown.

Record reviews of the resident's written care plan indicated that they were to be turned and repositioned every two hours from the time of admission.

A review of the resident's task list indicated that they were not turned every two hours until a start date on a specified date.

RPN (Registered Practical Nurse) confirmed the resident's admission date, was not turned every two hours as required and as ordered in the written care plan until start of a specified date.

Failing to ensure that care was provided to the resident as set out in the written plan of care, put them at risk of skin breakdown.

Sources: Interview with RPN, Resident's assessments, care plan, Kardex, Point of Care (POC) task list.[741754]

2) The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the director related to a complaint concerning staff did not perform safety checks on the resident during the night on a specified date.

The licensee's internal investigation notes indicated that the resident was checked by staff throughout the night, but not hourly as per the written plan of care. RPN confirmed that resident's care plan indicated to do safety check every hour during nighttime.

The Director of Care (DOC) acknowledged that the resident's care plan was not followed for hourly safety checks.

Failure to follow directions in the plan of care put the resident's health and safety at risk.

Sources: CIR, Internal Investigation notes, Interviews with RPN and DOC, and Resident's care plan.[741749]

WRITTEN NOTIFICATION: Communication and response system

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (a)

1) The Licensee failed to ensure that the home was equipped with a resident-staff communication and response system that can be easily seen, accessed, and used by resident at all times.

Rationale and Summary

A complaint was submitted to the Director related to the resident's care.

During the inspection, the resident was observed sitting in a specialized device in their room attempting to grab the call bell, which was observed to be tied to their bedrails. The resident indicated they were waiting for a Personal Support Worker (PSW) for a while and wanted to call for help, but were unable to reach the call bell. RPN confirmed that the resident was capable to reach and use a call bell when they needed assistance.

The DOC, RPN, and PSW acknowledged the expectation was to ensure that the call bell was within reach of the resident, and it was not to be tied to the bedrails.

Failure to ensure the call bell was easily accessible at all times, caused risk to resident's safety.

Sources: Observation, Interviews with resident, PSW, RPN, and DOC.[741749]

2) The Licensee failed to ensure that the home was equipped with a resident-staff communication and response system that can be easily seen, accessed, and used by resident at all times.

Rationale and Summary

A Critical Incident Report was submitted to the director related to a complaint from a family member concerning the resident's call bell that was not provided on a specified date, at night.

The licensee's internal investigation note indicated that the call bell was confirmed to have not been provided to the resident at a specified time and date.

The DOC acknowledged that the resident had no access to the call bell and the home expected to make sure that the resident always has access to the call bell.

Failure to ensure the call bell was within reach at all times caused risk to resident's safety.

Sources: CIR, Internal Investigation notes, Interview with DOC.[741749]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b),

1) The licensee has failed to ensure that a standard issued by the Director with respect to infection prevention and control was implemented. Specifically, IPAC standard 9.1 (e) the licensee failed to ensure that additional precaution shall include Point-of-care signage indicating that enhanced Infection Prevention and Control (IPAC) measures were in place.

Rationale and Summary

During the initial IPAC tour, the Inspectors observed a Personal Protective Equipment (PPE) caddy outside a resident's room without any additional precautions posted at the door. RPN confirmed that the resident was on additional precautions and indicated that the expectation was to have the signage posted at the door.

The DOC and IPAC lead indicated that signage should be posted outside the door of a resident room who was in additional precaution.

Failing to ensure signage is posted outside the door of residents who are under additional precautions increases the risk of the spread of infection in the home.

Sources: Observations, Interviews with RPN, DOC and IPAC lead.[741749]

2) The licensee has failed to implement any standard or protocol issued by the Director with respect to infection prevention and control was implemented. Specifically, IPAC standard 6.1 the licensee failed to ensure that shall make PPE available and accessible to staff and residents, appropriate to their role and level of risk.

Rationale and Summary

During the inspection, a PPE caddy did not contain the necessary PPE as indicated in the signage posted in a resident's room with additional precaution. Specifically, N95 masks and gloves were missing at the point of care.

An empty PPE caddy was observed outside a resident's room who was in isolation and required additional precautions on a specified unit.

In two separate observations on a specified unit, there was no PPE caddy observed outside a resident's room that was identified as requiring additional precaution.

The DOC and IPAC lead indicated that the expectation was to follow the required PPE signage and make sure PPE was replenished and available in the PPE caddies.

Failure to have PPE available and accessible to staff at the point of care posed a risk of harm to residents and staff from possible transmission of infectious agents.

Sources: Interviews with DOC and IPAC lead, Observations.[741749]